

		FOR OHF USE					

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2001  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2001)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH Facility ID Number:</b> <u>0032367</u></p> <p><b>Facility Name:</b> <u>RAINBOW BEACH NURSING CTR</u></p> <p><b>Address:</b> <u>7325 SOUTH EXCHANGE</u> <u>CHICAGO</u> <u>60649</u> Number City Zip Code</p> <p><b>County:</b> <u>COOK</u></p> <p><b>Telephone Number:</b> <u>(773) 731-7300</u> <b>Fax #</b> <u>(773) 731-5781</u></p> <p><b>IDPA ID Number:</b> <u>363523898001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>01/01/60</u></p> <p><b>Type of Ownership:</b></p> <table><tr><td><input type="checkbox"/></td><td><b>VOLUNTARY, NON-PROFIT</b></td><td><input checked="" type="checkbox"/></td><td><b>PROPRIETARY</b></td><td><input type="checkbox"/></td><td><b>GOVERNMENTAL</b></td></tr><tr><td><input type="checkbox"/></td><td>Charitable Corp.</td><td><input type="checkbox"/></td><td>Individual</td><td><input type="checkbox"/></td><td>State</td></tr><tr><td><input type="checkbox"/></td><td>Trust</td><td><input type="checkbox"/></td><td>Partnership</td><td><input type="checkbox"/></td><td>County</td></tr><tr><td><b>IRS Exemption Code</b></td><td></td><td><input type="checkbox"/></td><td>Corporation</td><td><input type="checkbox"/></td><td>Other</td></tr><tr><td></td><td></td><td><input checked="" type="checkbox"/></td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Other</td><td></td><td></td></tr></table> <p><b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Steve Lavenda</u> <b>Telephone Number:</b> <u>(847) 236 - 1111</u></p>	<input type="checkbox"/>	<b>VOLUNTARY, NON-PROFIT</b>	<input checked="" type="checkbox"/>	<b>PROPRIETARY</b>	<input type="checkbox"/>	<b>GOVERNMENTAL</b>	<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State	<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County	<b>IRS Exemption Code</b>		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other			<input checked="" type="checkbox"/>	"Sub-S" Corp.					<input type="checkbox"/>	Limited Liability Co.					<input type="checkbox"/>	Trust					<input type="checkbox"/>	Other			<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/01</u> to <u>12/31/01</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table><tr><td rowspan="2"><b>Officer or Administrator of Provider</b></td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____ (Date) _____</td></tr><tr><td rowspan="5"><b>Paid Preparer</b></td><td>(Title) _____</td></tr><tr><td>(Signed) <u>See Accountants' Compilation Report Attached</u></td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>ROBERT A. ROSE, C.P.A.</u></td></tr><tr><td>(Firm Name &amp; Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax# <u>(847) 236-1155</u></td></tr></table> <p><b>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</b></p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) _____ (Date) _____	<b>Paid Preparer</b>	(Title) _____	(Signed) <u>See Accountants' Compilation Report Attached</u>	(Date) _____	(Print Name and Title) <u>ROBERT A. ROSE, C.P.A.</u>	(Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax# <u>(847) 236-1155</u>
<input type="checkbox"/>	<b>VOLUNTARY, NON-PROFIT</b>	<input checked="" type="checkbox"/>	<b>PROPRIETARY</b>	<input type="checkbox"/>	<b>GOVERNMENTAL</b>																																																					
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Facility Name & ID Number RAINBOW BEACH NURSING CTR # 0032367 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	211	Intermediate (ICF)	211	77,015	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	211	TOTALS	211	77,015	7

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	70,542	366		70,908	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	70,542	366		70,908	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.07%

D. How many bed-hold days during this year were paid by Public Aid?  
1068 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)  
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?  
Date started 11/17/1987

J. Was the facility purchased or leased after January 1, 1978?  
YES ☒ Date 11/17/1987 NO ☐

K. Was the facility certified for Medicare during the reporting year?  
YES ☐ NO ☒ If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2001 Fiscal Year: 12/31/2001  
\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number RAINBOW BEACH NURSING CTR # 0032367 Report Period Beginning: 01/01/01 Ending: 12/31/01

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	278,504	21,018	8,160	307,682		307,682		307,682			1
2	Food Purchase		271,306		271,306	(32,704)	238,602	(14)	238,588			2
3	Housekeeping	322,496	25,579		348,075		348,075		348,075			3
4	Laundry		2,117	52,644	54,761		54,761		54,761			4
5	Heat and Other Utilities			224,892	224,892		224,892	(3,457)	221,435			5
6	Maintenance		39,076	78,992	118,068		118,068	(15,275)	102,793			6
7	Other (specify):*	78,244			78,244		78,244		78,244			7
8	<b>TOTAL General Services</b>	679,244	359,096	364,688	1,403,028	(32,704)	1,370,324	(18,746)	1,351,578			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			16,200	16,200		16,200		16,200			9
10	Nursing and Medical Records	1,249,413	28,293	1,358	1,279,064		1,279,064	(2,366)	1,276,698			10
10a	Therapy			3,269	3,269		3,269		3,269			10a
11	Activities	360,638	46,371	7,846	414,855		414,855		414,855			11
12	Social Services	147,303		263	147,566		147,566		147,566			12
13	Nurse Aide Training											13
14	Program Transportation			1,857	1,857		1,857		1,857			14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	1,757,354	74,664	30,793	1,862,811		1,862,811	(2,366)	1,860,445			16
	<b>C. General Administration</b>											
17	Administrative	382,129		182,809	564,938		564,938		564,938			17
18	Directors Fees											18
19	Professional Services			307,164	307,164		307,164	315	307,479			19
20	Dues, Fees, Subscriptions & Promotions			14,496	14,496		14,496	(1,100)	13,396			20
21	Clerical & General Office Expenses	67,341		253,740	321,081		321,081	(145,309)	175,772			21
22	Employee Benefits & Payroll Taxes			453,876	453,876	32,704	486,580		486,580			22
23	Inservice Training & Education											23
24	Travel and Seminar			875	875		875		875			24
25	Other Admin. Staff Transportation			2,451	2,451		2,451	(470)	1,981			25
26	Insurance-Prop.Liab.Malpractice			148,925	148,925		148,925	(2,548)	146,377			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	449,470		1,364,336	1,813,806	32,704	1,846,510	(149,112)	1,697,398			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,886,068	433,760	1,759,817	5,079,645		5,079,645	(170,224)	4,909,421			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			20,769	20,769		20,769	230,411	251,180			30
31	Amortization of Pre-Op. & Org.			4,375	4,375		4,375		4,375			31
32	Interest			72,361	72,361		72,361	540,525	612,886			32
33	Real Estate Taxes			259,242	259,242		259,242		259,242			33
34	Rent-Facility & Grounds			1,197,926	1,197,926		1,197,926	(1,197,926)				34
35	Rent-Equipment & Vehicles			21,565	21,565		21,565	(7,278)	14,287			35
36	Other (specify):*							6,759	6,759			36
37	TOTAL Ownership			1,576,238	1,576,238		1,576,238	(427,509)	1,148,729			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			115,523	115,523		115,523		115,523			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			115,523	115,523		115,523		115,523			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,886,068	433,760	3,451,578	6,771,406		6,771,406	(597,733)	6,173,673			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	7,561	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(14)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,912)	21		18
19	Entertainment				19
20	Contributions	(400)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(75,000)	21		24
25	Fund Raising, Advertising and Promotional	(700)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,591)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(100,615)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (178,671)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(419,062)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (419,062)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (597,733)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line
	Reference		
1	BANK FEES	\$ (57,271)	21 1
2	THEFT & DAMAGE LOSS	(1,850)	21 2
3	CABLE TV	(3,457)	5 3
4	S.S. KOSHER FRANCHISE TAX	(225)	20 4
5	S.S. KOSHER REPLACEMENT TAX	(8,295)	21 5
6	S.S. KOSHER BANK CHARGES	(120)	21 6
7	S.S. KOSHER PENALTIES	(90)	21 7
8	PATIENT CLOTHING	(2,366)	10 8
9	DEFERRED MAINTENANCE	4,535	6 9
10	PAINTING & DECORATING	(18,416)	6 10
11	NON ALLOW OFFICE EXP	(1,685)	21 11
12	ADDITIONAL LEGAL INVOICES	315	19 12
13	NON ALLOW GAS	(470)	35 13
14	LAND ROVER LEASE	(7,278)	35 14
15	NON ALLOW CAR REPAIRS	(1,394)	6 15
16	NON ALLOW CAR INSURANCE	(2,548)	26 16
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## STATE OF ILLINOIS

Summary A

Facility Name & ID Number RAINBOW BEACH NURSING CTR# 0032367

Report Period Beginning:

01/01/01

Ending:

12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary													1
2	Food Purchase	(14)											(14)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(3,457)											(3,457)	5
6	Maintenance	(15,275)											(15,275)	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	(18,746)											(18,746)	8
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(2,366)											(2,366)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>	(2,366)											(2,366)	16
	<b>C. General Administration</b>													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	315											315	19
20	Fees, Subscriptions & Promotions	(1,325)	225										(1,100)	20
21	Clerical & General Office Expenses	(153,814)	8,505										(145,309)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation	(470)											(470)	25
26	Insurance-Prop.Liab.Malpractice	(2,548)											(2,548)	26
27	Other (specify):*													27
28	<b>TOTAL General Administration</b>	(157,842)	8,730										(149,112)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(178,954)	8,730										(170,224)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number     RAINBOW BEACH NURSING CTR     #     0032367     Report Period Beginning:     01/01/01     Ending:     12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	7,561	222,850										230,411	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		540,525										540,525	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(1,197,926)										(1,197,926)	34
35	Rent-Equipment & Vehicles	(7,278)											(7,278)	35
36	Other (specify):*		6,759										6,759	36
37	TOTAL Ownership	283	(427,792)										(427,509)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(178,671)	(419,062)										(597,733)	45



## VII. RELATED PARTIES

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
AVA BURGHER	20	BLUE ISLAND NURSING HOME	BLUE ISLAND	S.S. KOSHER	CHICAGO	OWNER
ESTHER PERL	20					
BERTHA HELD	20					
HELENE ZATS	20					
RITA HOCHENBAUM	20					

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☒ **X** **YES** ☐ **NO**

**If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.**

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	\$ 1,197,926	SO. SHORE KOSHER REST HOME	100.00%	\$	\$ (1,197,926)	1
2	V	30	DEPRECIATION		SO. SHORE KOSHER REST HOME	100.00%	222,850	222,850	2
3	V	32	INTEREST EXPENSE		SO. SHORE KOSHER REST HOME	100.00%	540,525	540,525	3
4	V	21	BANK CHARGES		SO. SHORE KOSHER REST HOME	100.00%	120	120	4
5	V	36	MORTGAGE COSTS		SO. SHORE KOSHER REST HOME	100.00%	6,759	6,759	5
6	V	20	FRANCHISE TAX		SO. SHORE KOSHER REST HOME	100.00%	225	225	6
7	V	21	REPLACEMENT TAX		SO. SHORE KOSHER REST HOME	100.00%	8,295	8,295	7
8	V	21	PENALTIES		SO. SHORE KOSHER REST HOME	100.00%	90	90	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,197,926			\$ 778,864	\$ * (419,062)	14

**\* Total must agree with the amount recorded on line 34 of Schedule VI.**

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.



VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RAINBOW BEACH NURSING CTR # 0032367 Report Period Beginning: 01/01/01 Ending: 12/31/01

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RITA HOCHENBAUM	ADMINISTRATOR	ADMIN	20.00%	SEE ATTACHED	30	75.00%	SALARY	\$ 75,380	17-1	1
2	ZOHAR HOCHENBAUM	ADMINISTRATIVE	ADMIN	RELATIVE	SEE ATTACHED	32	64.00%	SALARY	82,436	17-1	2
3	ZOHAR HOCHENBAUM	ADMINISTRATIVE	ADMIN	RELATIVE				ADMIN FEES	130,559	17-3	3
4	MICHAEL PERL	ADMINISTRATIVE	ADMIN	RELATIVE	SEE ATTACHED			ADMIN FEES	52,250	17-3	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 340,625		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number RAINBOW BEACH NURSING CTR # 0032367 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_  
Street Address \_\_\_\_\_  
City / State / Zip Code \_\_\_\_\_  
Phone Number (\_\_\_\_\_) \_\_\_\_\_  
Fax Number (\_\_\_\_\_) \_\_\_\_\_

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number RAINBOW BEACH NURSING CTR # 0032367 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_  
Street Address \_\_\_\_\_  
City / State / Zip Code \_\_\_\_\_  
Phone Number (\_\_\_\_) \_\_\_\_\_  
Fax Number (\_\_\_\_) \_\_\_\_\_

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number RAINBOW BEACH NURSING CTR # 0032367 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_  
Street Address \_\_\_\_\_  
City / State / Zip Code \_\_\_\_\_  
Phone Number (\_\_\_\_) \_\_\_\_\_  
Fax Number (\_\_\_\_) \_\_\_\_\_

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number RAINBOW BEACH NURSING CTR # 0032367 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1					\$	\$			1
	2									2
	3									3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	\$		\$	25

Facility Name & ID Number RAINBOW BEACH NURSING CTR # 0032367 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_  
Street Address \_\_\_\_\_  
City / State / Zip Code \_\_\_\_\_  
Phone Number (\_\_\_\_) \_\_\_\_\_  
Fax Number (\_\_\_\_) \_\_\_\_\_

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25



Facility Name & ID Number RAINBOW BEACH NURSING CTR # 0032367 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_  
Street Address \_\_\_\_\_  
City / State / Zip Code \_\_\_\_\_  
Phone Number (\_\_\_\_) \_\_\_\_\_  
Fax Number (\_\_\_\_) \_\_\_\_\_

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number RAINBOW BEACH NURSING CTR # 0032367 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number RAINBOW BEACH NURSING CTR # 0032367 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number RAINBOW BEACH NURSING CTR # 0032367 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_  
Street Address \_\_\_\_\_  
City / State / Zip Code \_\_\_\_\_  
Phone Number (\_\_\_\_) \_\_\_\_\_  
Fax Number (\_\_\_\_) \_\_\_\_\_

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number RAINBOW BEACH NURSING CTR # 0032367 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	CORUS BANK		X	MORTGAGE	\$7,610	7/29/97	\$ 280,000	\$ 254,771	7/29/07	PRM+1.5	\$ 23,051	1	
2	CORUS BANK		X	MORTGAGE	INTEREST	7/29/97	4,820,000	4,711,248	7/29/07	IND +4.5	502,009	2	
3	CORUS BANK		X	MORTGAGE			150,000	130,895			15,466	3	
4												4	
5												5	
	Working Capital												
6	CORUS BANK		X	WORKING CAPITAL	INTEREST	7/29/97	750,000		DEMAND		60,664	6	
7	FIRSTAR		X	WORKING CAPITAL	INTEREST		1,000,000	996,290	DEMAND		6,682	7	
8	CHARLES FITCH		X	WORKING CAPITAL	INTEREST			164,000	DEMAND		5,015	8	
9	TOTAL Facility Related				\$7,610		\$ 7,000,000	\$ 6,257,205			\$ 612,887	9	
	B. Non-Facility Related*												
10	See Supplemental Schedule											10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 7,000,000	\$ 6,257,205			\$ 612,887	15	

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							\$				\$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							\$				\$	21





IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

RAINBOW BEACH NURSING CTR

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0032367

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-1111

FAX #:

(847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>21-31-112-004-0000</u>	<u>Long Term Care Property</u>	\$ <u>1,556.90</u>	\$ <u>1,556.90</u>
2. <u>21-30-112-007-0000</u>	<u>Long Term Care Property</u>	\$ <u>11,366.82</u>	\$ <u>11,366.82</u>
3. <u>21-30-112-008-0000</u>	<u>Long Term Care Property</u>	\$ <u>12,619.52</u>	\$ <u>12,619.52</u>
4. <u>21-30-112-011-0000</u>	<u>Long Term Care Property</u>	\$ <u>241.90</u>	\$ <u>241.90</u>
5. <u>21-30-112-012-0000</u>	<u>Long Term Care Property</u>	\$ <u>241.90</u>	\$ <u>241.90</u>
6. <u>21-30-112-013-0000</u>	<u>Long Term Care Property</u>	\$ <u>31,162.83</u>	\$ <u>31,162.83</u>
7. <u>21-30-112-014-0000</u>	<u>Long Term Care Property</u>	\$ <u>39,455.88</u>	\$ <u>39,455.88</u>
8. <u>21-30-112-017-0000</u>	<u>Long Term Care Property</u>	\$ <u>948.97</u>	\$ <u>948.97</u>
9. <u>21-30-112-018-0000</u>	<u>Long Term Care Property</u>	\$ <u>953.95</u>	\$ <u>953.95</u>
10. <u>21-30-112-051,052-0000</u>	<u>Long Term Care Property</u>	\$ <u>84,547.93</u>	\$ <u>84,547.93</u>
TOTALS		\$ <u>183,096.60</u>	\$ <u>183,096.60</u>

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?                 YES        X   NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.  
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 57,645

B. General Construction Type: Exterior BRICK

Frame BRICK

Number of Stories 4

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☐ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred: 7,500

2. Number of Years Over Which it is Being Amortized: 2

3. Current Period Amortization: 4,375

4. Dates Incurred: 9/19/2000

Nature of Costs: LINE OF CREDIT: 9/99-9/00=\$7,500, 9/00-9/01=\$7,500

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility			\$ 80,500	1
2					2
3	TOTALS			\$ 80,500	3

Facility Name &amp; ID Number RAINBOW BEACH NURSING CTR

# 0032367

Report Period Beginning:

01/01/01

Ending:

12/31/01

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	111			1960	\$ 231,825	\$	35	\$ 4,637	\$ 4,637	\$ 199,381	4
5				1961	2,200		35	44	44	1,848	5
6				1967	98,993		35	1,980	1,980	69,299	6
7				1969	7,014		35	175	175	5,950	7
8				1971	6,000		35	150	150	4,800	8
	<b>Improvement Type**</b>										
9	Various			1974	1,256		20	-		1,256	9
10	Various			1975	5,273		20	-		5,273	10
11	Various			1978	1,629		20	-		1,629	11
12	Various			1979	13,315		20	-		13,315	12
13	Various			1980	21,420		20	857	857	18,925	13
14	Various			1981	12,600		20	-		12,600	14
15	Various			1984	4,075		20	57	57	4,027	15
16	Various			1985	1,138		20	-		1,138	16
17	Various			1987	5,781		20	289	289	4,624	17
18	Various			1988	27,565		20	-		27,565	18
19	Various			1990	50,842		20	2,540	2,540	31,564	19
20	Various			1991	9,559		20	239	239	2,669	20
21	Various			1992	36,140		20	1,807	1,807	18,979	21
22	Various			1994	531		20	27	27	232	22
23	Various			1995	14,108		20	539	539	7,521	23
24	Various			1996	7,702		20	385	385	2,539	24
25	Various			1997	23,448		20	1,173	1,173	6,473	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

\*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$ -	\$	\$ -	37
38					-		-	38
39					-		-	39
40					-		-	40
41					-		-	41
42					-		-	42
43					-		-	43
44					-		-	44
45					-		-	45
46					-		-	46
47					-		-	47
48					-		-	48
49					-		-	49
50					-		-	50
51					-		-	51
52					-		-	52
53					-		-	53
54					-		-	54
55					-		-	55
56					-		-	56
57					-		-	57
58					-		-	58
59					-		-	59
60					-		-	60
61					-		-	61
62					-		-	62
63					-		-	63
64					-		-	64
65					-		-	65
66					-		-	66
67					-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)	6,308,716	168,422		162,762	(5,660)	770,776	68
69	Financial Statement Depreciation		9,911			(9,911)		69
70	TOTAL (lines 4 thru 69)	\$ 6,891,130	\$ 178,333		\$ 177,661	\$ (672)	\$ 1,212,383	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,891,130	\$ 178,333		\$ 177,661	\$ (672)	\$ 1,212,383	1
2	ROOFTOP HEATING	1998	18,441		20	922	922	3,919	2
3	HEATING COILS	1999	2,234		20	57	57	226	3
4	CUBICLE CURTAINS	1999	5,050		20	129	129	403	4
5	CUBICLE CURTAINS	1999	4,086		20	105	105	354	5
6	BOILER	2000	32,982		20	846	846	1,798	6
7	COMPRESSOR	2000	1,693		20	43	43	95	7
8	MASONRY	2000	30,000		20	769	769	2,147	8
9	ROOF	2000	34,625		20	1,731	1,731	2,936	9
10	FIRE DAMPER	2001	20,577		20	22	22	22	10
11	ROOF	2001	69,700		20	1,266	1,266	1,266	11
12	ROOF	2001	12,375		20	619	619	619	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,122,893	\$ 178,333		\$ 184,170	\$ 5,837	\$ 1,226,168	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 7,122,893	\$ 178,333		\$ 184,170	\$ 5,837	\$ 1,226,168	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,122,893	\$ 178,333		\$ 184,170	\$ 5,837	\$ 1,226,168	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,122,893	\$ 178,333		\$ 184,170	\$ 5,837	\$ 1,226,168	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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18									18
19									19
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,122,893	\$ 178,333		\$ 184,170	\$ 5,837	\$ 1,226,168	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 7,122,893	\$ 178,333		\$ 184,170	\$ 5,837	\$ 1,226,168	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,122,893	\$ 178,333		\$ 184,170	\$ 5,837	\$ 1,226,168	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 7,122,893	\$ 178,333		\$ 184,170	\$ 5,837	\$ 1,226,168	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,122,893	\$ 178,333		\$ 184,170	\$ 5,837	\$ 1,226,168	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 7,122,893	\$ 178,333		\$ 184,170	\$ 5,837	\$ 1,226,168	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,122,893	\$ 178,333		\$ 184,170	\$ 5,837	\$ 1,226,168	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 7,122,893	\$ 178,333		\$ 184,170	\$ 5,837	\$ 1,226,168	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,122,893	\$ 178,333		\$ 184,170	\$ 5,837	\$ 1,226,168	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 7,122,893	\$ 178,333		\$ 184,170	\$ 5,837	\$ 1,226,168	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,122,893	\$ 178,333		\$ 184,170	\$ 5,837	\$ 1,226,168	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	100		1999	1999	\$ 6,075,955	\$ 162,454	39	\$ 155,794	\$ (6,660)	\$ 758,148	4
5			2000	2000	232,761	5,968	39	6,968	1,000	12,628	5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
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60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,308,716	\$ 168,422		\$ 162,762	\$ (5,660)	\$ 770,776	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$398,500	\$65,286	\$65,727	\$441	10	\$289,393	71
72	Current Year Purchases	22,427		1,283	1,283	10	1,283	72
73	Fully Depreciated Assets	200,302				10	200,302	73
74								74
75	TOTALS	\$621,229	\$65,286	\$67,010	\$1,724		\$490,978	75

D. Vehicle Depreciation (See instructions.)*										
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets		1	2	
		Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,824,622	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 243,619	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 251,180	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,561	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,717,146	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)					
	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress			
	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YESNO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease.

9. Option to Buy: YES NO Terms: \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

16. Rental Amount for movable equipment: \$ 9,611 Description: COPIER=\$6,735, AIR PURIFIER=\$2,552, COOLER=\$324

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	BUSINESS	BMW	\$ 390	\$ 4,676	17
18					18
19					19
20					20
21	TOTAL		\$ 390	\$ 4,676	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending

Annual Rent

12. /2002 \$

13. /2003 \$

14. /2004 \$

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.



A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input type="checkbox"/> YES	2. <u>CLASSROOM PORTION:</u>	3. <u>CLINICAL PORTION:</u>
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<input checked="" type="checkbox"/> NO	IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE _____
		HOURS PER AIDE _____	

B. EXPENSES

ALLOCATION OF COSTS (d)

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

		1		2		3		4	
		Facility		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$							
2	Books and Supplies								
3	Classroom Wages (a)								
4	Clinical Wages (b)								
5	In-House Trainer Wages (c)								
6	Transportation								
7	Contractual Payments								
8	Nurse Aide Competency Tests								
9	TOTALS	\$		\$		\$		\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$							

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
(c) For in-house training programs only. Do not include fringe benefits.  
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

12345678											
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist		hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist		hrs							4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy		# of prescrpts							9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Exceptional Care Program									12	
13	Other (specify):									13	
14	TOTAL			\$		\$	\$		\$	14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits	65	65	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,800,586	1,800,586	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	119,701	119,701	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	686,306	34,222	8
9	Other(specify): See supplemental schedule	24,107	35,056	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,630,765	\$ 1,989,630	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		94,982	13
14	Buildings, at Historical Cost		6,667,842	14
15	Leasehold Improvements, at Historical Cost	395,795	448,759	15
16	Equipment, at Historical Cost	203,143	659,540	16
17	Accumulated Depreciation (book methods)	(232,187)	(1,442,565)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule		111,783	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 366,751	\$ 6,540,341	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,997,516	\$ 8,529,971	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 986,365	\$ 1,894,542	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	441,603	441,603	28
29	Short-Term Notes Payable	1,160,290	1,160,290	29
30	Accrued Salaries Payable	59,271	59,271	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,516	13,913	31
32	Accrued Real Estate Taxes(Sch.IX-B)	192,251	192,251	32
33	Accrued Interest Payable	1,747	62,715	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	6,500	6,500	35
	<b>Other Current Liabilities(specify):</b>			
36	See supplemental schedule	5,702	5,702	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,861,245	\$ 3,836,787	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		5,096,914	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	See supplemental schedule			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 5,096,914	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,861,245	\$ 8,933,701	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 136,271	\$ (403,730)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,997,516	\$ 8,529,971	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 26,433	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 26,433	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	725,965	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(616,127)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 109,838	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 136,271	24 *

\* This must agree with page 17, line 47.

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 7,497,371	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,497,371	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<a href="#">See supplemental schedule</a>		28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,497,371	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,403,028	31
32	Health Care	1,862,811	32
33	General Administration	1,813,806	33
	<b>B. Capital Expense</b>		
34	Ownership	1,576,238	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers		35
36	Provider Participation Fee	115,523	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,771,406	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	725,965	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 725,965	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? [Not Finished](#) If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number RAINBOW BEACH NURSING CTR# 0032367

Report Period Beginning:

01/01/01

Ending:

12/31/01

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 54,796	\$ 26.34	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	42,619	42,847	773,117	18.04	4
5	Nurse Aides & Orderlies	51,134	51,829	421,500	8.13	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	31,842	32,423	360,638	11.12	10
11	Social Service Workers	13,986	14,243	147,303	10.34	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	34,537	35,069	278,504	7.94	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	42,876	43,352	322,496	7.44	18
19	Laundry					19
20	Administrator	1,560	1,560	75,380	48.32	20
21	Assistant Administrator	2,080	2,080	68,025	32.70	21
22	Other Administrative	3,774	3,774	238,724	63.25	22
23	Office Manager					23
24	Clerical	9,732	9,732	67,341	6.92	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	5,932	5,970	78,244	13.11	33
34	TOTAL (lines 1 - 33)	242,152	244,959	\$ 2,886,068 *	\$ 11.78	34

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	179	\$ 8,160	01-03	35
36	Medical Director	731	16,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	11	578	10-03	38
39	Pharmacist Consultant	27	780	10-03	39
40	Physical Therapy Consultant	9	473	10a-03	40
41	Occupational Therapy Consultant	53	2,796	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	149	7,846	11-03	44
45	Social Service Consultant	5	263	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,164	\$ 37,096		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.



XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Painting & Decorating	1996	\$ 2,142		\$ 714	\$ 357							
2	Painting & Decorating	2000	4,398				733	1,466	1,466	733			
3	Painting & Decorating	2001	18,416					3,069	6,139	6,139	3,069		
4													
5													
6													
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19													
20	TOTALS		\$ 24,956		\$ 714	\$ 357	\$ 733	\$ 4,535	\$ 7,605	\$ 6,872	\$ 3,069	\$	\$



Facility Name &amp; ID Number RAINBOW BEACH NURSING CTR

# 0032367

Report Period Beginning: 01/01/01

Ending: 12/31/01

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? NO  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line \_\_\_\_\_
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO \_\_\_\_\_ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
SOUTH SHORE KOSHER REST HOME 11/17/1985
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 115,523  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? NO
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 32,704 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100%ln14  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees